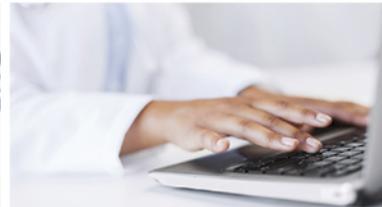# Prior Authorization Operating Rules: The Physician Perspective

NCVHS Subcommittee on Standards

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AMA
AMERICAN MEDICAL ASSOCIATION

Prior Authorization (PA): An Advocacy Priority for the AMA

- The patient care delays and administrative burdens associated with PA make this issue a top physician concern and AMA advocacy priority

- **First and foremost, the AMA urges all health plans to reduce overall utilization of PA and limit application to true outliers**

- When PA is used, the administrative burdens on physicians should be minimized through automation

PA: A Function Ripe for Automation

- Impact on patient care

  - 86% of physicians report that PA interrupts patient care[1]

- Burden on practices

  - *Time burden:* 1.0 physician hour/week; 13.1 nursing hours/week; 6.3 clerical hours/week[2]

  - *Cost burden:* $82,975 annually per physician on interactions with insurers[3]

- Cost to health plans

  - PA is largely a manual process and workflow for payers

1. MedChi. Prior Authorization Protocols: Impact on Patient Care in Maryland. July 20, 2011. 2. Casalino LP et al. *Health Aff* (Millwood). 2009;28:w533-w543. 3. Morra D et al. *Health Aff* (Millwood). 2011;30:1443-1450.

Current State of PA Automation

- PA is currently a very manual process involving faxes and phone calls

- In most cases, "electronic" PA means proprietary health plan portals—not use of standard electronic transactions

- During NCVHS Review Committee testimony in June 2015, there was widespread agreement across stakeholders that adoption of the ASC X12 278 is low

- In the PA DMEPOS final rule, CMS indicated that they "**expect** to have the ability to accept electronic 278 transmissions and will notify the public **when electronic 278 transmissions can be accepted**" [emphasis added]

Status of ASC X12 278 Implementation

Summary Table 1. Electronic Transaction Adoption, All Electronic Transactions, Health Plans, Healthcare Providers and Combined, 2013

(percent of transactions)

	Health Plans (HIPAA standardized, Web Portal, IVR)	Healthcare Providers (HIPAA standardized)	Plans and Providers Combined Average
Claim Submission	92%	92%	92%
Eligibility and Benefit Verification	95%	69%	82%
Prior Authorization	64%	7%	35%
Claim Status Inquiry	90%	54%	72%
Claim Payment	58%	58%	58%
Remittance Advice	55%	47%	51%

Source: 2014 CAQH Index. All responding health plans.

Notes: Electronic transactions include HIPAA standardized transactions, which are considered fully electronic for both health plans and healthcare providers, as well as "partially electronic" transactions via health plans' web portals or interactive voice response (IVR) systems, which are considered electronic for health plans, but manual for providers. Industry-wide adoption rates represent the average for health plans and providers.

Operating Rules to the Rescue!

- Existing operating rules have enhanced and improved electronic exchange of information

- Operating rules addressing data content have significantly increased value of electronic transactions, including:

  - Inclusion of real-time patient copay, coinsurance, and deductible information in eligibility responses

  - Uniform use of CARCs and RARCs in standard electronic remittance advice

Leveraging Operating Rules to Spur X12 278 Adoption

- Current X12 278 operating rules just address infrastructure, not data content
  - Connectivity, response times, and system availability are important to success of transactions, but **content** is also critical
  - Speed of transaction immaterial without exchange of **meaningful** data
  - While the AMA agrees with most of the infrastructure requirements, they are not sufficient to increase transaction use
- **We are missing a critical opportunity to boost PA automation if X12 278 operating rules do not include data content requirements**

PA as a Conversation

- As many stakeholders have noted, PA is a complicated work process involving a conversation between health plans/providers

- All PA steps must be conducted electronically to support and promote end-to-end process automation:

  - Providers must be able to inquire, and health plans must be able to report, if PA is required for a particular service as part of the electronic eligibility check

  - Upon a provider PA request, health plans must be able to indicate what specific information is needed to fulfill PA requirements for a particular service

  - Providers must be able to electronically submit, and health plans receive, supporting documentation related to PA requests

  - Health plans must be able to electronically send final PA determinations that will be received within the provider's PMS/EHR workflow

How Operating Rules Can Help Save the X12 278

- The industry has unfortunately taken a "bare minimum" approach to X12 278 implementation, with health plans merely acknowledging receipt of the PA request and indicating that no additional information will be sent electronically

- Providers are instructed to call the health plan or are referred to health plan portals to complete the PA process

- Operating rules could raise the bar for the industry and jumpstart adoption by requiring the 278 response to:
  - Indicate if PA is not needed
  - Communicate approval or denial of PA if no additional information is required for processing
  - Request additional information if needed for PA processing using the PWK segment
  - Communicate final PA determinations

- Operating rules should require **multiple iterations of the 278 response** to support end-to-end PA process automation
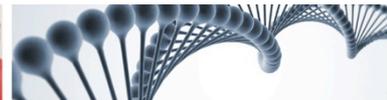
Other Missing Pieces to the PA Puzzle

- While the poor adoption of the X12 278 is an obvious impediment to PA automation, other transactional gaps must be addressed

- In addition to more robust operating rules for the X12 278, NCVHS should also recommend adoption of:

  - Operating rules for the X12 270/271 that would require the **procedure-specific** eligibility responses needed to communicate PA requirements to providers

  - A standard for electronic clinical attachments to allow submission of the supporting documentation needed for PA determinations
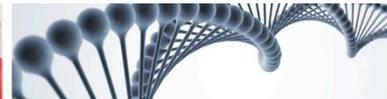
Recommendations: Carpe Diem

- The AMA appreciates the efforts of CAQH CORE to improve efficiency and standardization through operating rule development and sees value in the X12 278 infrastructure rules

- However, these rules are **not sufficient** to automate the process, drive the industry toward adoption, or reduce the current overwhelming burden of PA on physician practices

- We recommend taking the time to do a thorough gap analysis of what is needed to spur X12 278 adoption—including the addition of data content requirements—and addressing all identified issues in a more robust set of operating rules

- Complete PA automation will also require support for procedure-specific eligibility responses and a mandated clinical attachment standard

Opportunity: Breakthrough for Entire Industry

- Tremendous opportunity for all stakeholders to pull together in collaborative effort to address X12 278 adoption

- No blame, no finger-pointing: no one is using this transaction

- Multi-stakeholder effort needed for a "Save This Transaction" success story

- We can join together to improve patient care and reduce administrative burdens across the industry

Questions?

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